Substance misuse in young people; a brief (one-session) intervention (BI) framework for reducing hazardous or harmful use

A one-session planned or opportunistic BI for hazardous or problem substance misusers, based on the principles and techniques of Motivational Interviewing

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Introduction

There is evidence (see, for example, Gates, McCambridge, Smith and Foxcroft, 2006; McCambridge and Strang, 2004; Miller and Rollnick, 2002) for the use of one-session Brief Interventions that include the principles and style of Motivational Interviewing (MI) for reducing substance misuse in adolescents. These are generally based on Motivational Interviewing as described by Miller and Rollnick (2002) and incorporate offering advice and information about substance misuse. The one session does not include any assessment leading up to choosing to apply the intervention.

In order to deliver these motivational interventions (as opposed to other types of BI), it is essential that the practioner/therapist has been trained in MI together with the specifics of this manual. Training as a minimum should include firstly a two days skills-based workshop aimed at building MI competencies as well as an understanding of Motivational Stages of Change (Prochaska and DiClemente, 1984) and this BI Manual. And secondly, continued supervision in the practice of MI from someone with competencies in MI. It is recommended that booster MI training sessions are in addition carried out on a regular basis (for example one day of training per year in addition to on-going supervision). The Manual is written (and can only be understood) on the assumption that MI training has been completed

The BI described can be used both in specialist Child and Adolescent Substance Misuse Services as well as general clinical or non-clinical settings (for example in teenage antenatal clinics, primary health care, specialist youth services, educational and criminal justice settings). It is assumed that substance misuse has in some way been identified either by the client themselves, information provided by other professionals or through an assessment of the client's needs. The client target population includes recreational drinkers and drug users whose use carries potential harm, together with those who have already experienced some problems associated with their substance misuse including persistent substance misusers. The intervention may be helpful with dependent users in terms of motivation to seek further help but is unlikely to be helpful as a standalone intervention.

Although not essential, the BI is probably best delivered by staff who do not have to balance the collaborative style of this BI with any punitive or authority role. If this is not possible, then the session should at the very least be separate from other meetings etc. with the client.

The details of how the intervention is delivered (the words used, the complexity of examples etc.) will vary depending on the client group and setting. It is intended that this manual be used as a framework rather than a prescribed text, i.e. the words used should be adapted to suit the setting and

client, provided the basic principles, style and strategies described here are followed.

Aims of the intervention:

There are three main aims:

- to raise awareness about alcohol, smoking and/or drug use
- to increase motivation to change this
- to facilitate decision-making.

In one session you will not be able to cover everything below. Adapt the techniques so that they are relevant and appropriate for the client and miss out anything not relevant or appropriate. The most important element of this intervention is to make sure the overall style and principles of Motivational Interviewing (MI) are used. The actual techniques are less important.

The goals of the session will vary according to individual need, but will include:

Minimum		Maximum
Establish boundaries and demonstrate respect		Establish rapport
Identify and Communicate risk	Identify client goals	Resolve ambivalence
Provide information	Exchange information	Develop discrepancy
Initiate thinking about change in drug use/ drinking	Build motivation for change	Elicit commitment to change

Structure

This is a one-session meeting that may lead to referral onto other specialist services or a suggestion for the client to contact the G.P. but is more likely to be the only contact about their substance use. The intervention follows protocols for evidence-based single-session motivational interviewing (Miller and Rollnick, 2002)

Session length is 15-40 minutes depending on how willing the client is. The usual conditions for conducting a counselling session are needed; ideally, a room offering reasonable comfort and ensuring confidentiality without disturbance from others. **It is recognised, however, that these conditions are not often easy to meet so get as close to meeting them as possible.**

Content

This is based on the style and techniques of the Feedback and Information Exchange component of Motivational Interviewing (Miller and Rollnick , 2002)

as adapted by Miller for use in a brief intervention Miller, W.R. and Sanchez, V.C. (1994) and further adapted here for use with adolescents.

Miller uses the acronym "FRAMES" to describe the essential components for effective motivational BI (not, of course, delivered in this order):

Feedback Give the client objective feedback on their substance use, levels of consumption, and any relevant test results from clinical investigations.

Responsibility Emphasise that it is the client's personal responsibility for change

Advice Advice to make a change in levels/pattern of drinking.

Menu Offer a range of options for changing their behaviour

Empathy Good reflective and empathic listening retaining a non-judgemental attitude.

Self-efficacy An optimistic tone, give the client hope and realistic optimism, change is possible and never too late.

In MI with adolescents, the client has to be more of an equal collaborator than either the Service User or the Provider might be used to. This is not always the style in some settings. To avoid "premature focus", start off with agenda setting which is agreed by the client ("Is that alright with you?", "Are there other issues you would like to focus on?", etc). The client should be invited to prioritise. Part of your strategy is to get a better understanding of the client's perception about changing, rather than you assuming that it is important to change or that they have confidence they can do it.

There are two phases in MI (Building Motivation and Moving Towards Action). Both are appropriate to this Brief Intervention. For most people, however, (assuming clients are hazardous/harmful users rather than dependent users) the focus is going to be on the client developing awareness and knowledge about the negative effects of substance misuse and about building motivation for change. The four principles of MI apply to both phases:

PRINCIPLE 1: EXPRESS EMPATHY

- Acceptance (which does not mean agreement) facilitates change. A collaborative and inquisitive style with regards understanding rather than a "telling" style is crucial.
- Skilful reflective listening is fundamental.
- Ambivalence is normal.

PRINCIPLE 2: DEVELOP DISCREPANCY

- Awareness of consequences is important
- A discrepancy between present behaviour and important goals will motivate change.
- The client should present the arguments for change.

PRINCIPLE 3: ROLL WITH RESISTANCE

- Arguments are counterproductive
- Defending breeds defensiveness
- Resistance is a signal to change strategies
- Labelling is unnecessary
- Momentum can be used to good advantage
- Perceptions can be shifted
- New perspectives are invited but not imposed.
- The client is a valuable resource in finding solutions to problems

PRINCIPLE 4: SUPPORT SELF-EFFICACY

- Belief in the possibility of change is an important motivator
- The client is responsible for choosing and carrying out personal change
- There is hope in the range of alternative approaches available

The above are the principles. The strategies used in Phase I (building motivation) are:

1. Ask Open-Ended Questions
2. Listen Reflectively
3. Affirm
4. Summarise
5. Elicit Change Talk/Self Motivational Statements

It is essential that a good rapport is established from the start. A "teacher" stance is avoided and the style of a curious (the client is the expert on their substance use), supportive, collaborative helping interviewer is adopted. It is recognised this may be alien to both the client and the therapist but is nevertheless possible in most settings if the BI session is separated out from other activities if these are incompatible with this BI.

The fifth strategy described above (Elicit Change Talk/Self Motivational Statements) can be achieved through a number of techniques. Firstly, it is important to be aware of four categories or levels of change talk Miller and Rollnick, 2002):

Four categories of change talk
Recognising disadvantages of the status quo (problem recognition)
Recognising advantages of change
Expressing optimism about change
Expressing intention to change

These categories can be seen as levels the person moves through. In general, use the techniques described below starting at the first category (Problem Recognition) and moving up to the next once it is evident the client is ready.

How To Elicit Change Talk

Socratic Questionning and Guided Discovery (refer back to your training and discuss in supervision as, like many of the skills described in this Manual, they are more complex than they may initially appear) are used to help guide the client through the four categories:

1. Asking Evocative Questions

1.1 Disadvantages of the status quo

• What worries you about your current drinking/drug use/smoking?	• What difficulties have you had in relation to your drug use?
• In what ways does this concern you?	• In what ways do you think your smoking/drinking has been harmful?
• What are the problems with your current smoking/drugs use/drinking?	• What do you think will happen if you don't change anything?

1.2 Advantages of change

• How would you like things to be different?	• What would be the good things about quitting/cutting down?
• If you woke up tomorrow morning and no longer (used ketamine/cannabis/crack/drank alcohol etc) how might things be better for you?	• What would be the advantages of making this change?

1.3. Optimism about change

• Who could offer you helpful support in making this change?	• What encourages you that you can change if you want to?

• What's telling you that if you did decide to make a change, you could do it?	• What do you think would work for you, if you decided to change?

1.4. Intention to Change

• From what you've been saying it seems that at least a part of you might be thinking it's time to do something. What next?	• What things make you think that you should keep on drinking the way you have been?….And what about the other side? What makes you think that it's time for a change?

2. Exploring Pros and Cons (the Decisional Balance or Pay-Off Matrix)

Good things/not so good things a. of carrying on at this level
b. of drinking/using less

3. Asking for Elaboration

Asking for clarification: *"in what ways?" "how much?" "when?"*
Asking for a specific example: *"you said at the club you….Tell me more about that."*
Asking for an example of the last time this occurred (e.g. having to borrow money to pay a debt, or feeling particularly bad about having sex when drunk).

4. Querying/Imagining Extremes

"What's the worst/best that could happen if you do/don't cut down?"

5. Looking Forward

"How would you like your life to look in a year's time? And how does your current bingeing fit in with that?"

6. Looking Back

"How were things for you before you started using ketamine?"

7. Siding with the Negative

"Maybe you're right, smoking cannabis really isn't any problem for you and perhaps this is something you'll do for the rest of your days"

8. Exploring goals and values

"What are the things that you value most or want to achieve most? And how does your current drug use fit in with this?"

9. Using the importance and confidence rulers

Remember the two key questions using the 0-10 rating scale or ruler:

"Imagine a ruler or rating scale that goes from zero, (where zero means not at all), to ten (which means the maximum score possible)"

"How important is it for you to drink less ……?"

"How confidant are you that if you did stop doing E, you could stick at it?"

Ask the client to rate each on a scale of 0 to 10.

Further questions: For importance *"Why a score of X and not (a lower number)?"*

For confidence *"What would it take/What would have to happen for the score to move from X to (a higher number)?"*

Phase II Moving Towards Action

This probably most often means "What next?" followed by feedback and giving advice. For some, it could possibly include completing a change plan worksheet (see later) if they have reasonable writing skills and comprehension (if not, then think imaginatively how this could be made fun for the client, such as doing it on a computer or with a simpler, more pictorial, chart). This part of MI is usually started with you giving a summary of what the client has said to you about their smoking/drug use/drinking, remembering to include the pros and cons of continuing to use drugs/drink at this level or the pros and cons of change,

A suggested format for Moving Towards Action:

1. A summary of the client's own perceptions of the problem, as reflected in his or her self-motivational statements.

2. A summing-up of the client's ambivalence, including what remains positive or attractive about the problem behaviour.

3. A review of whatever objective evidence you have regarding the presence of risks and problems.

4. A restatement of any indications the client has offered of wanting, intending, or planning to change.

5. Your own assessment of the client's situation, particularly at points where it converges with the client's own concerns.

Follow this summary with a key question (usually some variant of "what next"):

Possible Key Questions

What do you think you will do?

What does this mean about your drinking?

It must be uncomfortable for you now, seeing all this…. What's the nest step?

What do you think has to change?

What could you do? What are your options?

It sounds like things can't stay the way they are now. What are you going to do?

Of the things I have mentioned here, which for you are the most important reasons for a change?…. How are you going to do it?

What's going to happen now? Where do we go from here?

How would you like things to turn out for you now, ideally?

What concerns you about changing your drinking?

What would be some of the good things about making a change?

6. Providing feedback and giving advice.

Try to seek the client's permission before giving advice:
"would it be OK if I gave you some of my thoughts on this?"

If you make suggestions, qualify them and allow the client to judge how well it suits them:
"I don't know if this would work for you but I can give you an idea of what other people have found useful"
"this might not make any sense in your case, let me know what you think, but it sounds to me that……"
"everyone is different and this might not apply to you, but other people who continue to take/smoke/drink etc ……."

Try to make it collaborative by avoiding the "expert" trap, push responsibility back to the client.
Try to give advice only when invited to do so by the client.
"I'll be happy to give you some ideas but I don't want to get in the way of any ideas you have for yourself- you're the expert on you"

"I'll be happy to give you some ideas but maybe you've got some ideas of your own about what to do"

Offer several options, allow the client to choose what they will do with these:
"Let me describe a number of possibilities and you tell me what makes most sense for you".

Feedback is an interactive, circular process. Rollnick proposes **ELICIT-PROVIDE-ELICIT** technique:

ELICIT Readiness/Interest	*"What would you most like to know about …?"* *"How much do you know about ….?"*
PROVIDE feedback neutrally	Keep to objective information Avoid any personal interpretation Talk about "other clients" Avoid "you" language
ELICIT client's interpretation	"What do you make of that?" "What does this mean for your future drinking?"

Hazards to avoid:

1. Underestimating Ambivalence (no point talking about change advice if a precontemplator who does not recognise there's a problem or a need to change)
2. Overprescription (too much advice with few options)
3. Insufficient direction/ Not giving clear advice to change (some people will benefit from clear advice to change and how to do this).

7. Negotiating a Plan

7.1 Setting Goals

- what it is you want to change
- what are the consequences of change (what might go wrong)

7.2 Considering Change Options

- a "menu" approach
- advice on "matching"
- don't be discouraged by "failure"

7.3 Arriving at a Plan

- the change plan worksheet

8. Checking it all out

8.1 Eliciting Commitment

8.2 Transition to the Action Stage

Handling Resistance (applicable in both Phase I work and Phase II)

Resistance can take several forms (Miller and Rollnick, 2002):

1. **Arguing.** The client contests the accuracy, expertise, or integrity of the therapist.
   1a. *Challenging*. The client directly challenges the accuracy of what the therapist has said.

1b. *Discounting.* The client questions the therapist's personal authority and expertise ("what do **you** know about ketamine, have **you** ever even taken it?".

1c. *Hostility*. The client expresses direct hostility toward the therapist.

2. **Interrupting.** The client breaks in and interrupts the therapist in a defensive manner.

2a. *Talking over.* The client speaks while the therapist is still talking, without waiting for an appropriate pause or silence.

2b. *Cutting off.* The client breaks in with words obviously intended to cut the therapist off (e.g. "I've had about enough of this")

3. **Denying.** The client expresses an unwillingness to recognise problems, cooperate, accept responsibility, or take advice.

3a. *Blaming.* The client blames other people for problems.

3b. *Disagreeing.* The client disagrees with a suggestion that the therapist has made, offering no constructive alternative. This includes the familiar "Yes, but….." which explains what is wrong with suggestions that are made.

3c. *Excusing.* The client makes excuses for his or her own behaviour

3d. *Claiming impunity*. The client claims that he or she is not in any danger (e.g. from drinking).

3e. *Minimising.* The client suggests that the therapist is exaggerating the risks or dangers, and that it "really isn't so bad"

3f. *Pessimism.* The client makes general statements about self or others that are pessimistic, defeatist, or negativistic in tone.

3g. *Reluctance.* The client expresses reservations and reluctance about information or advice given.

3h. *Unwillingness to change.* The client expresses a lack of desire or an unwillingness to change, or an intention not to change.

4. **Ignoring**. The client shows evidence of not following or ignoring the therapist

4a. *Inattention*. The client's response indicates that he or she has not been following or attending to the therapist.

4b. *Nonanswer*. In answering a therapist's query, the client gives a response that is not an answer to the question.

4c. *No response.* The client gives no audible or nonverbal reply to a therapist's query.

4d. *Sidetracking.* The client changes the direction of the conversation that the therapist has been pursuing.

Be aware of:

a. YOUR Role in Resistance (how are you inadvertently creating/adding to it?)

b. Recognising Resistance

c. Strategies for Handling Resistance (remember to re-read your training notes and discuss in supervised practice sessions as these are complex and often difficult to put into practise).

Reflection Strategies for Handling Resistance

1. Simple Reflection (e.g. *"So it sounds as if what you are saying is……..)*
2. Amplified Reflection: slightly exaggerate (but avoid any sarcasm) the negative aspect of what the client has said (e.g. *"You don't see any problems in your drug use…….*
3. Double-Sided Reflection *("on the one hand …….and on the other hand……..."*

Strategic Responses for Handling Resistance

1. Shifting Focus (e.g. *"perhaps that's something we could discuss at another time……")*
2. Emphasising Personal Choice and Control (*it really is your choice", "you're the one to make that decision", "no one can decide that for you"*)
3. Positive Reframing (this is a complex cognitive therapy technique; only use this if you feel confident in its use).
4. Agreement with a twist (a simple reflection followed by a reframe; same warning as above).
5. Siding with the Negative ("Therapeutic Paradox") (This involves you taking the negative side of what the client has said; it can go wrong *("the social worker has told me to carry on smoking skunk even though it's making me ill and she thinks I'll probably be doing it for the rest of my days……"*).So only use if you are confident it will have the effect of the client taking the opposite argument).

AN EXAMPLE OF A POSSIBLE SESSION

Part 1.

Introduction and rapport-building

Take a few minutes to introduce yourself to the client (if your first meting) and to thank them for agreeing to see you (e.g. *"I'm really pleased you've agreed to discuss your smoking and drinking with me*").

Give an overview of the session unless this is inappropriate; how long (up to 40 minutes) you will be meeting for and what **your** goals are, but with an emphasis on explaining that within these limits it is the client's own goals that will be the focus. Describe the approach (described below).

Here is a detailed, over-long narrative of what you might say. In practise, use your own words and keep it as simple and as brief as possible:

Before we begin, let me just explain a little about what this is about. You've already spent some time talking to other people here. In this meeting I want to discuss with you about smoking/drinking/using drugs.

I should also explain right from the start that I want to find out what you want for you; I'm not going to be lecturing you or trying to make you change anything you don't want to change. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing, you will be the one who does it. Nobody can tell you what to do; nobody can make you change. I may be able to give you some information about yourself and maybe some advice, but what you do with all of that after our meeting together is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is you. How does that sound to you?

Remember, clients can be powerfully affected by the arguments they hear *themselves* make, rather than being lectured to by you. Your job is to raise awareness and motivation to change and to facilitate decision-making. **Elicit change talk: a recognition of a problem around drugs/alcohol/smoking, concerns about this, intention to change, optimism about change.**

Part 2. Review of current situation and further rapport building

Briefly discuss with the client their current situation and perception of their pattern of smoking/drug use/drinking and level of consumption.

A good opener might be:

- *Tell me about how things are going for you at the moment.*

Some open-ended questions you can ask around **PROBLEM RECOGNITION** are:

- *Can you tell me more about your current drinking?*
- *What problems are causing you concern?*
- *What concerns do you have about your current drinking?*

Alternatively, use the Decision Balance Technique if appropriate here. Start with the positives: *"Tell me about the good things about smoking/drinking/using drugs for you. What do you enjoy about drinking, what do you get out of it that is helpful or enjoyable?"*

Allow time for elaboration, use reflections and ask open-ended questions.

Then the flip side: *"Tell me about the not so good things about your drinking, what kind of problems or difficulties does drinking cause to you or others?"*

If you are using the Decision Balance as a technique, you could use the form below and write the points down (or better still, get the client to write them down).

Either go into Advice and Information Giving (Part 5 below) or into Part 3:

Part 3. Beyond problem recognition (if appropriate)

Use the examples given above for other questions relevant to other levels of change talk.

Use the Importance Ruler and Confidence Ruler Techniques described above if appropriate to this client. Remember to ask the follow up questions designed to elicit change talk.

- *Why are you at a ….. and not 0?*
- *What would it take for you to go from …….. to (a higher number)?*

Remember <u>*not*</u> to ask *"Why are you at ….. and not 10?"*

Where appropriate use other techniques described above for eliciting change talk but do not go beyond "where the patient is at" in terms of motivation for change.

After this, either go into Advice and Information Giving (Part 5 below) or into Part 4:

Decision Balance Matrix.

Behaviour:

Positive consequences		Negative consequences	
Short term	Long term	Short term	Long term

Part 4. Moving Towards Action (if appropriate)

If the client is at the Action for Change phase, give a summary following the directions above. Ask the "what next?" question.

If appropriate, use the section described earlier for Negotiating a Plan.

Use the attached Change Plan Worksheet headings (or get the client to fill this in for themselves if appropriate). Now go into Advice and Information Giving (Part 5 below):

Part 5. Providing feedback and giving advice (include with all clients)

Follow the guidance given above for how to phrase this. Remember to be non-judgemental, no threats *("if you don't cut down then ……..")* and avoid saying *"you".*

"Other people with this level of drinking are very likely to……..." This helps avoid the client feeling in a corner.

"This might not necessarily work for you, but other people have found keeping a drug or drink diary/ talking the options through with someone trained in this field/ having a period of abstinence/getting their levels down to below XXX units per day with at least two alcohol-free days" etc etc has helped prevent problems.".

Part 6. Ending

Check with the client if there's anything else they would like to find out from you. If there's anything the client has said they will do, go over how they will do this and if possible get this written down and left with the client.

You are always polite and respectful, but try to add to this with thanks to the client and if possible a non-sarcastic affirmation. Many adolescents will find this approach unusual (if not totally alien to them) and it's easy to sound sarcastic but done properly it will make the client much more likely to take on board the session's content. Not to be said verbatim, but something along the lines of: *"I realise you've probably got other things to do than talk about your drug use/ drinking to me/ it isn't easy talking about personal stuff like we have:--so well done. I really respect you for being willing to spend this time talking to me about your drinking. I know it's not easy, but I hope this has been helpful to you"*.

CHANGE PLAN WORKSHEET

Name:

The changes I want to make are:		
The most important Reasons why I want to make these changes are:		
The steps I plan to take in changing are:		
The ways other people can help me are:	Person	Possible ways to help
I will know my plan is working if:		
Some things that could interfere with my plan are:		

References

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Other key references for MI with young substance misusers can be found at:

www.niaaa.nih.gov
www.nida.nih.gov
The NIDA (National Institute on Drug Abuse) and NIAAA (National Institute on Alcohol Abuse and Alcoholism) therapy manuals are available on their respective websites.

www.motivationalinterview.com
A website produced by the International Association of Motivational Interviewing Trainers, which contains updates on research, bibliography, news of training events and a trainer's newsletter.